APPENDIX B

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TECHNOLOGY ASSISTED WAIVER/EPSDT

NURSING SERVICES PROVIDER

SKILLS CHECKLIST FOR INDIVIDUALS CARING FOR TRACHEOSTOMIZED AND/OR VENTILATOR ASSISTED CHILDREN AND ADULTS

Agency Name _____
Office Location _____
Name of Nurse Providing Service _____

ASSESSMENTS	Experience Yes	No	Date of Most Recent Experience
Breath Sounds – Auscultation:			
Before Suction			
After Suction			
Need for Aerosol			
Signs & Symptoms:			
Respiratory Distress			
Hypoxia			
Side Effects of Medications			
Fluid Retention			
PROCEDURES			
Chest Physical Therapy			
Suctioning:			
Positioning for			
Nasopharyngeal			
Trachea			
Trach Care:			
Clean Trach Site			
Change Trach Ties			
Change Trach Tube			
Cleaning of Inner Cannula			
Place on Trach Collar			
Manual Resuscitation Device Application:			
Via Trach			
Via Mouth			
Emergency Protocol/Procedure:			
Knowledge of Individualized Plan			
Monitoring & Equipment:			
Vital Signs			
Skin Care			
Oral Hygiene			
Use of Apnea/Bradycardia Monitor			
Placement on Oxygen Delivery Device/Trach Collar			

	Experience Yes	No	Date of Most Recent Experience
Monitoring & Equipment (Continued):			
Placement on Ventilator			
Calibrate Oxygen Analyzer			
Check Oxygen Level/Liter Flow/Tank Level			
Check/Calibrate Ventilator Settings			
IMV			
PEEP			
Pressure Units			
Tidal Volume			
Systematic Troubleshooting of Ventilator			
Use of Respirometer			

Humidity System:			
Check Water Level			
Check Temperature			
Filling Procedure			
Draining Water from Tubing			
Cleaning of Humidity Bottles/Cascade			
Check Compressor Operation			
Clean Compressor Unit Screen			
Assess Suction Machine Pressure			
Clean Suction Machine			
Clean Suction Catheters			
Clean Corrugated Tubing			
Clean Manual Resuscitation Device (Reservoir Bag & Assoc. Equip)			
Clean Trach Collar			
Clean Trach Tubes			
Disposable			
Metal			

Medication Administration:			
Administration Technique (as appropriate)			
Installation of Normal Saline			
Administration of Aerosol Treatments			

Additional Individualized Assessments/Skills

_____ _____
_____ _____
_____ _____

I (Supervisor/Designee) _____, have inserviced the individual designated as Orientee regarding assessments and skills listed above.

Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

*Please indicate N/A when nonapplicable

SKILLS CHECKLIST FOR NURSES CARING FOR INDIVIDUALS WITH NUTRITIONAL NEEDS

Agency Name _____
Office Location _____
Name of Nurse Providing Service _____

ASSESSMENTS:	Date Describe	Date Demo
Assess and Record Intake and Output		
Assess Signs and Symptoms:		
Dehydration		
Fluid Retention		
Procedures/Techniques:		
Weight		
Skin Care:		
GT Site		
NG Site		
PO (By Mouth) Feeding:		
Preparation of Special Formula/Feeding		

Nasogastric Feeding:

Preparation of Special Formula/Feeding		
Insert NG Tube		
Check NG Placement		
Check NG Residual		
Bolus Feed		
Use of Feeding Pump		

Gastrostomy Feeding:

Insert GT Tube		
Check Placement of GT Tube		
Bolus Feed		
Use of Feeding Pump		

Hyperalimentation (As Per Physicians Orders):

Reading/Checking Hyperalimentation Prescription		
Operation of Infusion Pump		
Troubleshooting of Infusion		
Placement/Care of Infusion Line		

I (Supervisor/Designee) _____, have inserviced the individual designated as Orientee regarding assessments and skills listed above.

Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

*Please indicate N/A when nonapplicable

OBJECTIVE SCORING CRITERIA

Individual's Name _____ Principal Diagnosis _____

HCC _____ Admit Date _____

TECHNOLOGY	POINTS	DATE							
Vent Dependent total	50								
intermittent	45								
Trach	43								
C-PAP, BIPAP	25								
Oxygen, continuous	15								
O2, continuous, unstable	35								
G-tube continuous	15								
G-tube, cont. with reflux	35								
NG tube continuous	40								
bolus	25								
IV therapy continuous	40								
SUBTOTAL TECHNOLOGY									
NURSING NEEDS									
Suctioning >q1hr.	5								
q1-4hrs	3								
q4hrs+	2								
NG/GT Feeds continuous	5								
q 2hrs	4								
q3hrs	3								
q4hrs	2								
Medication simple	2								
moderate	4								
complex	8								
Intermittent cath. q4hrs	8								
q8hrs	6								
q12hrs	4								
qd or PRN	2								
Dressings q 8hrs or less	3								
>q8hrs	2								
Trach change and care	5								
IV/Hyperal continuous	8								
8-16hrs	6								
4-7 hrs	4								
<4hrs	2								
Special TX QID	8								
TID	6								
BID	4								
QD	2								
Specialized monitor I/O	5								
>3 hosp. in last yr or 3 mo. cont	5								
Other									
SUBTOTAL NURSING									
TOTAL POINTS									
DAILY NURSING HOURS.									

Signature of person completing form _____ Date _____

Instructions on Use of Objective Scoring Tool for Technology Assisted Waiver

1. All recipients will be scored on admission and every 3 months thereafter by the Health Care Coordinator.

2. Individuals must receive a minimum score of 50 to be admitted to the waiver or if already a waiver recipient, to remain on the waiver.

3. Individuals must receive a score in the technology section of the form to qualify for waiver services. Scores in the technology section are adjusted to reflect the risk of death or disability if the technology is lost as well as the degree of nursing assessment/judgment needed to operate the technology. Scores in the nursing needs section reflect the time needed to perform the skill. The size of the total score for the nursing needs section will be used to determine the need for "substantial and ongoing" nursing care.

4. Ventilator dependent individuals will not receive a technology score for tracheostomy. The need for this technology is included in the score for ventilator.

5. Oxygen must be continuous and needed at least 12 hours per day. If a individual has a diagnosis of BPD and continuous oxygen, 24 hours per day and meets any two of the following conditions, he/she is eligible for the increased points for unstable oxygen:

   On diuretics
   Albuterol treatments at least q4hrs around the clock
   Weight is below 15th percentile for age and gain does not follow normal curve for height
   >3 hospitalizations in last 6 months for respiratory problems
   Daily desaturations below doctor ordered parameters and desaturations require nursing intervention
   Physician ordered restricted fluid intake

6. For a individual to qualify for the increased G-tube points, the individual must have documented one of following conditions:

   swallow study that documents reflux within the last six months
   treatment for aspiration pneumonia in the past 12 months
   need for suctioning due to reflux (not oral secretions) a least daily

7. Several areas in the nursing needs section assign points based on the frequency of the need for the activity, e.g. trach suctioning q1hr. The individual's nursing record must support the chosen frequency. The nursing notes and HCC report must document that the individual needs this frequency of suctioning on an ongoing basis. It is understood that when a individual has an upper respiratory infection, the need for suctioning increases, the frequency determination should not be based on this time period but on the time when a individual is "well". A individual is ineligible for points in the suctioning category if he is able to suction his own trach.

8. Medication points are awarded based on the complexity of the individual's medication regimen. Individuals who are on only one or two routine medications that do not require dosage adjustment based on the individual's condition will receive the "simple medication" points. Individuals who are on more than two medications , one or more of which require close monitoring of dosage, side effects etc. will receive the "moderate medication" points. Individuals who are on more than 6 medications given on different frequency schedules or who need close monitoring of dosage/side effects of more than 4 different medications will receive the "complex medication" points. Some individuals receive multiple PRN

medications. DMAS must receive documentation that the individual is actually receiving these meds on a frequent basis for these medications to qualify for "complex" points. Nebulizer treatments do not count as medications. Neither vitamin nor mineral supplements count as medications.

9. Sterile dressing changes only are eligible for points. Individuals with a trach are ineligible for dressing change points. This is included in the trach care point determination.

10. Special treatments include nebulizer, chest PT etc. that are done on a routine basis. Treatments must require a skilled professional e.g. ROM or splint application are not special treatments. If the treatments are done together, e.g. nebulizer treatments followed by chest PT,TID, the points for TID should be awarded. If the individual has multiple treatments that are given at different schedules that add up to a total of more than 4 treatments per day,. then the QID points can be awarded. For example, a individual gets chest PT BID and specialized ostomy care TID. This individual would be awarded 8 points because of a total frequency of greater than 4 times per day. A individual cannot be awarded more than 8 points in this category no matter how many treatments they receive.

11. Specialized I/O monitoring is reserved for individuals who need careful monitoring of intake and output. Normally this monitoring would be due to the need for replacement fluids if the output is too large. Types of individuals who would need this type of monitoring are those with kidney problems, severe dumping syndrome etc. Normal daily measurement of I/O without the need to assess for replacement is not eligible for these points. One way to differentiate whether a individual is eligible for these points is to ask if the nurse does anything with the data. If she does nothing, or just calls the doctor, the individual is ineligible for these points. If she has to make adjustments in tube feeding amounts or rates, the individual is eligible.

12. Recipients get points for hospitalizations if they have been admitted (not emergency room visits) more than 3 times in the past year or had one continuous admission of 3 months or longer in the past 12 months. Recipients who have been hospitalized since birth and are just now going home for the first time are eligible for these points. **Please note** if a individual has not been rehospitalized in the last three month period, the HCC should check carefully whether the individual is still eligible for these points.

13. The Other category is for **major** procedures that are not covered elsewhere on the form, e.g. peritoneal dialysis. If you have a individual that you feel has **major** needs that are not covered, contact the DMAS analyst with information on what the procedure is and the amount of nursing time needed to perform this care. The analyst will review the information and assign a point score for the procedure. Only the DMAS analyst can assign points for procedures in the Other category.

14. After assigning the points in all the relevant categories, total the points and record at the bottom of the page.

15. Individuals will be scored every 3 months. It is expected that if total points start to decline indicating the individual is improving, that total nursing hours will also decline. A copy of the score sheet will be sent to DMAS each time the individual is scored.

DEFINITIONS

Oxygen, continuous- Individual must require oxygen a minimum of 12 hours out of 24.

Oxygen, unstable, - Dependent on oxygen 24 hours per day plus any 2 of the following:
- Diuretics
- Albuterol treatments at least q4hrs around the clock
- Weight is below 15th percentile for age and gain does not follow normal curve for height
- >3 hospitalizations in last 6 months for respiratory problems
- Daily desaturation below doctor ordered parameters and desaturation requires nursing intervention
- Physician ordered restricted fluid intake

G-tube with reflux - Individual has continuous G-tube feeds plus one of the following
- swallow study within the last 6 months that demonstrated reflux
- aspiration pneumonia within the last 12 months
- need for suctioning due to reflux (not oral secretions) on a daily basis

Simple medication - One or two medications not requiring dosage adjustment

Moderate medication - More than two meds that required close monitoring of dosage, side effects etc.

Complex medication - Six or more meds on different frequency schedules OR
Four or more meds requiring close monitoring of dosage and side effects

Dressings - Sterile dressings only. Trach dressings are **not** included in this category

Special Treatments - Other treatments that are considered skilled e.g. nebulizer. ROM is not a special treatment.

Specialized I/O monitoring - Monitoring that includes judgment of fluid replacement needs

PROCEDURE FOR REFERRALS TO TECHNOLOGY ASSISTED WAIVER

1. To be eligible for the Technology Assisted Waiver, a individual must be dependent on a technology to replace a vital body function, need substantial and ongoing skilled nursing care, as indicated on the objective scoring criteria, and not have hospitalization or nursing home insurance.

2. If you have a individual in your facility that you believe meets the criteria for admission to the Technology Assisted Waiver, you must complete the following procedure.

- Complete the objective scoring criteria form to ensure the individual meets the minimum nursing needs (a score of 50). If the individual does not score a 50 and you still believe the individual should qualify for the program, call a Health Care Coordinator to discuss the case before proceeding further.

- If the individual scores at least a 50 on the Objective Scoring Tool, the staff at the facilityis then responsible for completing the pre-assessment forms (2 pages). All information must be provided. If any section is not applicable to the individual, please write NA.

- Have a parent or legally responsible person sign the Consent for Release of Information form.

- Mail or fax all the completed forms, Objective Scoring Criteria, 2 page pre-assessment and the Consent, to the Health Care Coordinator assigned to your area. If you do not know who your Health Care Coordinator is, please call the MCH unit at DMAS, (804) 786-1465.

For HCCs based in Richmond, the address is:

DMAS
600 E. Broad Street
Suite 1300
Richmond, VA 23219

FAX # (804) 786-5799

In Roanoke

DMAS
Commonwealth Building
210 Church Ave.
Suite 330
Roanoke, VA 24011

FAX # (540) 857-6035

3. Once all the information is received, the Health Care Coordinator will review the packet and if it is determined the individual is apparently eligible, will schedule a meeting/home visit with the parents/caregivers. A home visit is required before a individual can begin services.

4. The Health Care Coordinator will assist the family or recipient in choosing a nursing and medical equipment provider. However, in working with the family at the hospital, the discharge planner can begin discussing this with the family. If the family has already chosen providers, it will speed the enrollment process.

5. The Health Care Coordinator will notify the person who completed the 3 page assessment packet and the family once a decision regarding approval or denial is reached.

TECHNOLOGY ASSISTED WAIVER AND EPSDT ASSESSMENT

GENERAL INFORMATION

Name of Applicant _____ Home Address _____

Directions to Home _____

Name of Primary Caretaker _____ Relationship _____ Telephone # _____

Name of Emergency Contact _____ Relationship _____ Telephone # _____

Family Income _____ Income Source _____

Birthdate_____
MO/DAY/YR

SEX
Male____Female____

___$20,000 or More
___$15,000 - 19,999
___$10,000 - 14,999
___$5,000-9,999
___less than $5,000
____Employment
____SSA/SSI
____ADC
_____Other
_____
(Specify)

HEALTH CARE COVERAGE:

MEDICAID #__ __ __ __ __ __ __ __ __ __ __ __

MEDICARE #_____

OTHER TYPE # _____

Name of Carrier_____

Social Security No. _____

If not currently Medicaid eligible,
has application been made? Yes_____ No_____

Date of Application _____

Name and phone # of Local DSS Eligibility Dept.

_____

_____

ALL CURRENT DIAGNOSES

_____

_____

_____

_____

TECHNOLOGY(S) NEEDED TO SUSTAIN LIFE

_____

_____

_____

_____

SCORE ON OBJECTIVE CRITERIA TOOL _____

BRIEF MEDICAL HISTORY: Date of admission to hospital_____ Expected date of discharge_____

_____

_____

_____

_____

_____

Name and Phone # of Community physician_____

Name and Phone # of Family 's Pharmacy_____

TECHNOLOGY ASSISTED WAIVER AND EPSDT ASSESSMENT

Name of Applicant_____

Physical and Skilled Needs Assessment

Brief description of status and description of any special care needs_____

Respiratory
Assessment

_____

GI/Nutrition
Assessment

_____

Cardiovascular
Assessment

_____

Urinary
Assessment

_____

Neurological
Assessment

_____

Integumentary
Assessment

_____

Motor/Muscular
Assessment

_____

Other Needs
(Medication, equipment)

_____

Immunizations up to date:Yes_____No_____(If no list needed immunizations below)

_____

Other pertinent information e.g. lab tests, X-rays etc.

_____

_____

ASSESSMENT OF IN HOME SUPPORT NEEDS

ANCILLARY NEEDS	FREQUENCY NEEDED	DATE REFERRED	PROVIDER(Name and phone)
PT			
OT			
Speech			
Respiratory			
Rehabilitation			
Infant Stimulation			
Educational Services			
Nutrition			

_____ _____ _____

Signature and Title of Person Completing Assessment Date Completed

TECHNOLOGY ASSISTED WAIVER AND EPSDT ASSESSMENT

Name of Applicant_____

FAMILY INFORMATION

Primary Caregivers: _____Relationship to applicant _____
If custody not held by Primary Caregiver, identify name, address and telephone # of custodian

_____

Marital Status of Primary Caregivers: _____If separated/divorced, describe living

and custody arrangements _____

Current employment/education of Primary Caregivers:

Name:_____
Employer_____
Address of employer_____
Phone # of employer_____
Work hours _____
Education level_____

Name_____
Employer_____
Address of employer_____
Phone # of employer_____
Work hours_____
Education level_____

Total Number of Persons Living in Home _____

NAME	AGE	RELATIONSHIP TO APPLICANT

Identify Significant Caregivers Not Living in Home (give name, address and relationship)

_____

_____

Why does the family desire home care _____

_____

What does the family express as potential problems of concerns with home care

_____

_____

_____

Describe other Stressors within the family (e.g. other handicapped individual, care of elderly parent, recent change in employment, recent relocation, recent death, alchoholism, depression etc.):

_____

_____

_____

Who is the primary decision maker _____

Describe family interactions with the patient _____

_____

TECHNOLOGY ASSISTED WAIVER AND EPSDT ASSESSMENT

Name of Applicant_____

Home Assessment

Type of Home: Apartment_____ House_____ Trailer_____ One Floor_____ Two Floors _____

Applicant's room location_____ Shared With_____

Describe Family's Willingness and Ability to Care for the Applicant (Indicate Training Received, Note Type and Amount of Care Family is Committed to Provide and Variations in Family Schedule)

_____

_____

_____

_____

Describe General Condition of the Home Environment and Any Concerns (e.g. cleanliness, pests)

_____

_____

Physical Facility Standard for the Home (If inadequate, note needed changes)	Adequate	Inadequate
STORAGE	_____	_____
9X9 FT MINIMUM SQ. FT. AREA FOR APP.	_____	_____
TELEPHONE SERVICE	_____	_____
POWER FAILURE LIGHT	_____	_____
LARGE BATTERY LIGHT AT BEDSIDE	_____	_____
SMOKE ALARM/FIRE EXT ON EACH LEVEL	_____	_____
BACK UP FUSES AVAILABLE	_____	_____
ADEQUATE # ELECTRIC OUTLETS IN ROOM	_____	_____
PLUMBING SUPPORTS WATER AND SEWAGE	_____	_____
ADEQUATE HEATING SYSTEM	_____	_____
ADEQUATE COOLING SYSTEM IF NECESSARY	_____	_____

Assessment: Conclusion regarding home environment's suitability for individual's needs

_____

_____

_____ _____

Signature of Health Care Coordinator Date

TECHNOLOGY ASSISTED WAIVER AND EPSDT ASSESSMENT

Name of Applicant_____

_____(Patient) has been assessed to determine whether he/she requires a hospital or skilled nursing facility level of care but can receive skilled nursing care in the home as an alternative. Based on this assessment, the following is recommended:

_____ Home Care is Approved Home care for this technology-assisted individual is appropriate to adequately meet the recipient's needs. The Plan of Care developed assures that all other non-Medicaid resources have been explored and services recommended are medically necessary and accurately reflect the individual's needs.

_____Individual requires a hospital or nursing facility level of care, the cost of which would be reimbursed by Medicaid.
_____Home environment is safe and therapeutic, (waiver services cannot be initiated until HCC confirms neccessary home modifications have been completed.)
_____Family has completed required training.
_____Community resources are available to support the service needs of the individual.
_____Plan of Care is Cost effective.

_____ Home Care is Not Approved

_____Individual does not require a hospital or nursing facility level of care, the cost which would be reimbursed by Medicaid.
_____Appropriate Plan of Care could not be developed. Reason_____
_____Plan of Care not cost effective
_____Family decided Home Care was not a viable option.
_____No provider agency available.
_____Other_____

_____	_____	_____	_____
Health Care Coordinator	Date	Physician, HCC Team	Date
_____	_____	_____	_____
Registered Nurse, HCC Team	Date	Social Worker, HCC Team	Date
_____	_____		
Community Attending Physician	Date		

In accordance with the policies and procedures of the Department of Medical Assistance Services, I have been informed by the Health Care Coordinator of the Medicaid-funded options available to me and I choose:

_____Home Care _____Hospital/Skilled Nursing Facility Care

I have been given a choice of the available providers _____Yes _____No
I understand and approve the recommended plan of care. I agree to assume responsibility for maintaining a safe and therapeutic environment that supports this plan of care. In adddition, I agree to perform those tasks designated in the plan of care as my responsibility. I also agree to assume responsibility for all required services in the event of an emergency.

_____	_____	_____	_____
Primary Caregiver	Date	Legally Responsible Person (if different)	Date

TECHNOLOGY ASSISTED WAIVER AND EPSDT ASSESSMENT

Name of Applicant_____

EMERGENCY SUPPORT - Emergency procedures established with, include date notified:

RESCUE SQUAD Date Notified_____

Name:_____ Contact_____

Address:_____ _____

EMERGENCY ROOM Date Notified_____

Name:_____ Contact_____

Address:_____ _____

FIRE DEPARTMENT Date Notified_____

Name:_____ Contact_____

Address:_____ _____

POLICE DEPT. Date Notified_____

Name:_____ Contact_____

Address:_____ _____

RED CROSS Date Notified_____

Name:_____ Contact_____

Address:_____ _____

ELECTRIC CO. Date Notified_____

Name:_____ Contact_____

Address:_____ _____

TELEPHONE CO. Date Notified_____

Name:_____ Contact_____

Address:_____ _____

GAS COMPANY Date Notified_____

Name:_____ Contact_____

Address:_____ _____

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen: ___/___/___
Assessment: ___/___/___
Reassessment: ___/___/___

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ (Last) _____ (First) _____ (Middle Initial) Client SSN: ___-___-___

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone: ( ) _____ City/County Code: _____ _____ _____

Directions to House: Pets?

Demographics

Birthdate: ___/___/___ (Month) (Day) (Year) Age: _____ Sex: ___ Male 0 ___ Female 1

Marital Status: ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race:
- ___ White 0
- ___ Black/African American 1
- ___ American Indian 2
- ___ Oriental/Asian 3
- ___ Alaskan Native 4
- ___ Unknown 9 _____

Ethnic Origin: _____

Education:
- ___ Less than High School 0
- ___ Some High School 1
- ___ High School Graduate 2
- ___ Some College 3
- ___ College Graduate 4
- ___ Unknown 9

Specify: _____

Communication of Needs:
- ___ Verbally, English 0
- ___ Verbally, Other Language 1
  Specify: _____
- ___ Sign Language/Gestures/Device 2
- ___ Does Not Communicate 3

Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationship: _____

Address: _____ Phone: (H) _____ (W) _____

Name: _____ Relationship: _____

Address: _____ Phone: (H) _____ (W) _____

Name of Primary Physician: _____ Phone: _____

Address: _____

Initial Contact

Who called: _____ (Name) _____ (Relation to Client) _____ (Phone)

Presenting Problem/Diagnosis:

CLIENT NAME: CLIENT SSN:

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	Provider/Frequency:
___	___	Adult Day Care	
___	___	Adult Protective	
___	___	Case Management	
___	___	Chore/Companion/Homemaker	
___	___	Congregate Meals/Senior Center	
___	___	Financial Management/Counseling	
___	___	Friendly Visitor/Telephone Reassurance	
___	___	Habilitation/Supported Employment	
___	___	Home Delivered Meals	
___	___	Home Health/Rehabilitation	
___	___	Home Repairs/Weatherization	
___	___	Housing	
___	___	Legal	
___	___	Mental Health (Inpatient/Outpatient)	
___	___	Mental Retardation	
___	___	Personal Care	
___	___	Respite	
___	___	Substance Abuse	
___	___	Transportation	
___	___	Vocational Rehab/Job Counseling	
___	___	Other: _____	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from . . . ?

No 0	Yes 1		*Optional: Amount*
___	___	Black Lung,	
___	___	Pension,	
___	___	Social Security,	
___	___	SSI/SSDI,	
___	___	VA Benefits,	
___	___	Wages/Salary,	
___	___	Other,	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		*Names*
___	___	Legal Guardian,	
___	___	Power of Attorney,	
___	___	Representative Payee,	
___	___	Other,	

Do you receive any benefits or entitlements?

No 0	Yes 1	
___	___	Auxiliary Grant
___	___	Food Stamps
___	___	Fuel Assistance
___	___	General Relief
___	___	State and Local Hospitalization
___	___	Subsidized Housing
___	___	Tax Relief

What types of health insurance do you have?

No 0	Yes 1		
___	___	Medicare, #	
___	___	Medicaid, #	
		Pending:	☐ No 0 ☐ Yes 1
		QMB/SLMB:	☐ No 0 ☐ Yes 1
___	___	All Other Public/Private:	

CLIENT NAME: Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House: Own 0				
___ House: Rent 1				
___ House: Other 2				
___ Apartment 3				
___ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40			Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent Weekly or more 3	External Device Not self care 4	Indwelling Catheter Not self care 5	Ostomy Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

	Needs Help?	
	No 0	Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section ➔ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

CLIENT NAME: Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0	Yes 1		Location
___	___	Living Will,	
___	___	Durable Power of Attorney for Health Care,	
___	___	Other,	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses — Date of Onset

Enter Codes for 3 Major, Active Diagnoses: ___ None 00 ___ DX1 ___ DX2 ___ DX3

	Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Total No. of Medications: ___ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: ___

Do you have any problems with medicine(s) . . . ?

No 0	Yes 1	
___	___	Adverse reactions/allergies
___	___	Cost of medication
___	___	Getting to the pharmacy
___	___	Taking them as instructed/prescribed
___	___	Understanding directions/schedule

How do you take your medicine(s)?

___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

Diagnoses:

- Alcoholism/Substance Abuse (01)
- Blood-Related Problems (02)
- Cancer (03)
- Cardiovascular Problems
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- Dementia
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- Developmental Disabilities
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich's Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland) Problems
  - Diabetes (19)
  - Other Endocrine Problems (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- Neurological Problems
  - Brain Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- Psychiatric Problems
  - Anxiety Disorders (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- Respiratory Problems
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- Urinary/Reproductive Problems
  - Renal Failure (40)
  - Other Urinary/Reproductive Problems (41)
- All Other Problems (42)

CLIENT NAME: Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	Previous Rehab Program?	Previous Rehab Program?
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	Date of Amputation?	Onset of Paralysis?
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: _____ (inches) Weight: _____ (lbs.) Recent Weight Gain/Loss: ___ No 0 ___ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
___	___	Food Allergies
___	___	Inadequate Food/Fluid Intake
___	___	Nausea/Vomiting/Diarrhea
___	___	Problems Eating Certain Foods
___	___	Problems Following Special Diets
___	___	Problems Swallowing
___	___	Taste Problems
___	___	Tooth or Mouth Problems
___	___	Other: _____

CLIENT NAME: Client SSN:

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0	Yes 1		*Frequency*
___	___	Occupational	
___	___	Physical	
___	___	Reality/Remotivation	
___	___	Respiratory	
___	___	Speech	
___	___	Other	

Do you have any pressure ulcers?

		Location/Size
___	None 0	
___	Stage I 1	
___	Stage II 2	
___	Stage III 3	
___	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0	Yes 1		*Site, Type, Frequency*
___	___	Bowel/Bladder Training	
___	___	Dialysis	
___	___	Dressing/Wound Care	
___	___	Eyecare	
___	___	Glucose/Blood Sugar	
___	___	Injections/IV Therapy	
___	___	Oxygen	
___	___	Radiation/Chemotherapy	
___	___	Restraints (Physical/Chemical)	
___	___	ROM Exercise	
___	___	Trach Care/Suctioning	
___	___	Ventilator	
___	___	Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: Please tell me your full name (so that I can make sure our record is correct).

Place: Where are we now *(state, county, town, street/route number, street name/box number)*?
Give the client 1 point for each correct response.

Time: Would you tell me the date today *(year, season, date, day, month)*?

___ Oriented 0
___ Disoriented - Some spheres, some of the time 1
___ Disoriented - Some spheres, all the time 2
___ Disoriented - All spheres, some of the time 3
___ Disoriented - All spheres, all of the time 4
___ Comatose 5

Spheres affected: _____

Recall/Memory/Judgement

Recall: I am going to say three words, and I want you to repeat them after I am done (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgement: If you needed help at night, what would you do?

No 0 Yes 1
___ ___ Short -Term Memory Loss?
___ ___ Long-Term Memory Loss?
___ ___ Judgement Problem?

Optional: MMSE Score

_____ (3)
_____ (3)
_____ (3)
_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?

___ Appropriate 0
___ Wandering/Passive - Less than weekly 1
___ Wandering/Passive - Weekly or more 2
___ Abusive/Aggressive/Disruptive - Less than weekly 3
___ Abusive/Aggressive/Disruptive - Weekly or more 4
___ Comatose 5

Type of inappropriate behavior: _____ Source of information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

CLIENT NAME: Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

___ ___ Solitary Activities, _____

___ ___ With Friends/Family, _____

___ ___ With Groups/Clubs, _____

___ ___ Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children

___ No Children 0
___ Daily 1
___ Weekly 2
___ Monthly 3
___ Less than Monthly 4
___ Never 5

Other Family

___ No Other Family 0
___ Daily 1
___ Weekly 2
___ Monthly 3
___ Less than Monthly 4
___ Never 5

Friends/Neighbors

___ No Friends/Neighbors 0
___ Daily 1
___ Weekly 2
___ Monthly 3
___ Less than Monthly 4
___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ No 0 ___ Yes 1

CLIENT NAME: Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1
Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with....

No 0 Yes 1
___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you....

No 0 Yes 1
___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

CLIENT NAME: Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.

Caregiver Assessment

Does the client have an informal caregiver?

___ No 0 (Skip to Section on Preferences) ___ Yes 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

_____

_____

Family/Representative's preferences for client's care: _____

_____

_____

Physician's comments (if applicable): _____

_____

_____

CLIENT NAME: Client SSN: - -

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)
___	___	Finances
___	___	Home/Physical Environment
___	___	ADLS
___	___	IADLS

No 0	Yes 1	(Check All That Apply)
___	___	Assistive Devices/Medical Equipment
___	___	Medical Care/Health
___	___	Nutrition
___	___	Cognitive/Emotional
___	___	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

DMAS PRIVATE DUTY NURSING PLAN OF CARE

NAME _____ DMAS ID # _____

NURSING AGENCY _____ PROVIDER ID # _____

CAREGIVER SCHEDULE FOR NURSING AND HOME CARE NEEDS

SECTION I

NURSING AND HOME CARE NEEDS	**Nursing Provides**	**Family Provides**	**Other Provides**
	RN/LPN Hrs/day Days/wk	Family Hrs/day Days/wk	Other Hrs/day Days/wk
Total of All Nursing & Home Care	____ Day ____	____ Day ____	____ Day ____
	____ Evn ____	____ Evn ____	____ Evn ____
	Nte	Nte	Nte
TOTAL HOURS OF CARE Specify Days of Week	**Hrs/day** ____ **days/wk** ____	**Hrs/day** ____ **days/wk** ____	**Hrs/day** ____ **days/wk** ____

SECTION II

SPECIFIC NURSING & HOME CARE TASKS	**CHECK THOSE PROVIDED BY:**		
	NURSING PROVIDES	**FAMILY PROVIDES**	**OTHER PROVIDES**
Respiratory Therapy			
Equipment Support			
Suctioning			
Vital Signs			
Administer Meds			
Nutritional Support			
Toileting			
Bath/Skin Care			
Mobility			
Ostomy Care			
Supervision			

EFFECTIVE DATE OF PLAN OF CARE _____ **REVISION DATE** _____

Home care is appropriate to adequately meet this person's needs. All other resources have been explored prior to Medicaid authorization for this individual.

AGENCY NURSE **DATE** **PATIENT/FAMILY** **DATE**

HEALTH CARE COORDINATOR/CASE MANAGER **DATE APPROVED**

INSTRUCTIONS FOR PRIVATE DUTY NURSING PLAN OF CARE

The DMAS Private Duty Nursing Plan of Care (DMAS-102) is completed for all recipients receiving Private Duty Nursing. It is also completed each time there is a revision in the number of nursing hours provided.

For recipients receiving Private Duty Nursing services for the first time, the top two sections of the form are completed.

Nursing and Home Care Needs

In Section 1, Nursing Provider, the number of hours per day of skilled nursing provided by the agency is recorded. If a recipient receives 8 hours during the day five days per week and eight hours during the evening seven days per week, the block would be completed as follows.

NURSING AND HOME CARE NEEDS	Nursing Provider			
	RN/LPN Hrs/day		Days/wk	
Total of All Nursing & Home Care	8	Day	5	
	8	Evn	7	
	0	Nte	0	
TOTAL HOURS OF CARE	Hrs/day	16	days/wk	7
Specify Days of Week	AM – Monday - Friday			
	PM – Monday - Sunday			

For Technology Assisted Waiver/EPSDT recipients any hours of care not being provided by the nursing agency must be provided by a family member or other provider. In the above example, the family or other provider would be required to provide eight hours of care at night every day and eight hours of care during the day on Saturday and Sunday. Who will provide this care and the hours they will provide must be documented in the Family and Other providers blocks of Section 1.

When the total hours of care from each of the three sections are added, it must equal 24 hours per day, seven days per week.

In Section 2, Nursing and Home Care Needs, all skilled needs for the recipient should be listed. For each task, the types of providers who will perform that task should be checked. For example, for a child with a tracheotomy, all care givers will provide suctioning so all providers should be checked. However, only the nursing agency will perform vital signs so the Family and Other Providers blocks would not be checked for that category. If the recipient does not have a need for a skill listed, the block should be left blank. For example, a recipient is on a ventilator but does not have an ostomy, the ostomy blocks would be left blank for all providers.

The Effective Date of Plan of Care is completed for all new Private Duty Nursing recipients. This is also filled in if a new DMAS-102 is completed because the nursing agency changes. The Revision Date is completed only if there is a revision to the Plan of Care, i.e. the total number of hours of nursing provided per week changes. Authorization of respite hours is **not** a Plan of Care revision.

A copy of all DMAS-102's will be kept in the Private Duty Nursing Agency and the Health Care Coordinator/Case Manager's recipient files.

MONTHLY NURSING STATUS REPORT

Agency: _____ Date of Supervisor visit: _____

Primary Nurse: _____ Month of service reported: _____

Recipient: _____ Medicaid #: _____

Orders renewed date: _____ Primary Diagnosis: _____

PLAN OF CARE-Services provided per plan: yes / no Health, safety and welfare needs met: yes / no

Nursing hours authorized/day: _____ Respite hours provided: _____ Total Respite hours used to date: _____

CURRENT CLINICAL STATUS Changes/Comments: _____

_____

PROBLEMS NOTED WITH DME (e.g. too much, too little, improper usage, agency): _____

_____

TECHNOLOGY/NURSING NEEDS: (Circle Answer) Ventilator CPAP BIPAP – continuous intermittent

Oxygen: continuous intermittent back up only NG/GT feeds: continuous q2hrs. q3hrs. q4hrs+

IV/Hyperal: continuous 8-16hrs. 4-7hrs. <4hrs. Oral Supplements: _____
(type, frequency, amount)

Trach Care: QD BID TID Trach Change: weekly <weekly Suctioning: qhr. Q1-4hrs. q4hrs+

Other dressings: _____ q8hrs or less >q8hrs Medications: _____
(Specify type and location)

Peritoneal dialysis (frequency and length) _____ _____

Catheterization: q4hrs q8hrs q12hrs QD PRN Special TX: _____ QID TID BID QD
(specify)

Specialized monitor I/O (specify): _____ frequency _____

Other skilled nursing (specify): _____

_____

HOSPITALIZATIONS/REASONS: _____

THERAPIES (name of provider, frequency, given where, progress): _____

_____

FAMILIES RESPONSE TO NURSING SERVICES: _____

_____

NURSES STAFFING CASE THIS MONTH: _____

_____

PROBLEMS IDENTIFIED: _____

_____

_____ _____ _____
RN SUPERVISOR SIGNATURE AGENCY PHONE # DATE

DMAS-103

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CLIENT)

_____
(CLIENT'S ADDRESS) *(CLIENT'S BIRTH DATE)* *(CLIENT'S SSN - OPTIONAL)*

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the client *(except drug or alcohol abuse diagnoses or treatment information)* to be exchanged:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits /Services Needed Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records

Other Information (write in):

I want: _____

_____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following other agencies to be able to exchange this information:

Are More Agencies Listed on Back? YES ☐ NO ☐

I want this information to be exchanged ONLY for the following purpose(s):

☐ Service Coordination and Treatment Planning ☐ Eligibility Determination

Other (write in): _____

I want information to be shared: (check all that apply)

☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until: _____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): _____ **Date:** _____
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: _____
(Name) *(Title)* *(Phone Number)*

Witness (If Required): _____
(Signature) *(Address)* *(Phone Number)*

DMAS-20
6/94

UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT:_____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED:_____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____

(AGENCY REPRESENTATIVE'S FULL NAME AND TITLE)

_____

(AGENCY ADDRESS AND TELEPHONE NUMBER)

Recipient's Name_____ HCC_____

RIGHTS AND RESPONSIBILITIES IN THE TECHNOLOGY ASSISTED WAIVER

Your family member has been admitted to the Department of Medical Assistance Services Technology Assisted Waiver. Your family member has been admitted because he/she

is dependent on a technology, which is_____

AND

requires substantial and ongoing skilled nursing care as determined by the Objective Criteria Scoring Tool, Score on admission_____

When your family member no longer meets **both** criteria, he/she will be discharged from the program. Though your family member may have substantial care needs, they may not all require a skilled person. For example, bathing, getting up, range of motion exercises, applying splints, and feeding do not require a skilled nurse. Only skilled needs are used to determine eligibility for the waiver.

Recipient's Rights in the Technology Assisted Waiver

1. You have the right to discontinue services at any time by notifying your Health Care Coordinator.
2. You have the right to change nursing agencies or equipment companies if you become dissatisfied with your current provider. In some areas there are a lack of providers, if you wish to change, please contact your Health Care Coordinator and she will assist you in locating another provider.
3. You have the right to be treated with courtesy and respect by all persons with whom you come in contact that are associated with the Technology Assisted Waiver. If you feel you are not being treated with courtesy and respect, please contact the CBC Supervisor at DMAS (804) 786-1465.
4. You have the right to appeal any decisions made by the Health Care Coordinator.

Parental/Caregiver Responsibilities

1. You have the responsibility to provide care when there is no nurse present in the home.
2. You have the responsibility to provide care or arrange care when a nursing agency is unable to staff a shift due to illness, weather or other reasons.
3. You have a responsibility to inform the nursing agency, in advance, when you do not need a nurse during an otherwise scheduled shift.
4. You have a responsibility to properly care for all equipment provided by DMAS. This includes preventing children from playing with or abusing equipment.
5 You have a responsibility to notify your DME provider when supplies or equipments are not being used or are not needed in the quantity being supplied.
6. You have a responsibility to inform your Health Care Coordinator of any change in the recipient's condition, whether an improvement or a deterioration. You must also notify the Health Care Coordinator and the nursing agency if the recipient is hospitalized.
7. You have a responsibility to notify your Health Care Coordinator if you believe you need to change the plan of care.

Nursing Agency Responsibilities

1. The nursing agency is responsible for providing skilled nurses in accordance with the plan of care developed by you and your Health Care Coordinator.
2. The nursing agency is responsible for providing nurses who are on time, clean, professional and attentive to the health needs of the recipient.
3. The nurses are responsible for caring for your family member's health needs; they are not baby-sitters, or chauffeurs. Nurses are **not** allowed to transport the recipient in a car, however, they are allowed to accompany the recipient in a vehicle if it is necessary for him/her to go out.
4. If your nursing agency is unable to staff a shift, it has a responsibility to try and make-up the missed hours within 72 hours of the missed shift. However, if the agency is unable to make up the missed hours during this time period, the hours cannot be made up at a later date.

Health Care Coordinator Responsibilities

1. The Health Care Coordinator (HCC) has a responsibility to regularly assess the recipient for continued eligibility to receive waiver services. This should include, at minimum, a home visit every 6 months.
2. The HCC has a responsibility to work with you to develop a plan of care that meets the recipient's medical needs.
3. The HCC has a responsibility to help you access other services, therapies, etc. that are needed to maximize the recipient's potential.
4. The HCC has a responsibility to work with you to plan and prepare for the eventual discharge of the recipient from waiver services.

Respite Care

You are eligible to receive up to 360 hours a year of respite care. Respite is designed to provide relief to the caregiver. Respite can be approved for:

medical appointments, hospitalizations or other medical needs of the caregivers
vacations when the recipient is being left at home
periodic evenings out

Respite cannot be authorized for regularly scheduled meetings such as card groups, sports leagues social groups, etc. Caregivers are **strongly** encouraged to use respite carefully and try to reserve some for use in case of emergencies..

SIGNATURES

Caregiver_____ Date_____

HCC_____ Date_____

To reach your HCC you may call (804) 786-1465 or 1-888-323-0589
In Southwest Virginia please call (540) 857-7342

Recipient's Name_____ HCC_____

RIGHTS AND RESPONSIBILITIES IN THE EPSDT PRIVATE DUTY NURSING PROGRAM

Your family member has been admitted to the Department of Medical Assistance Services EPSDT Private Duty Nursing Program. Your family member has been admitted because he/she

is dependent on a technology, which is_____

AND

requires substantial and ongoing skilled nursing care as determined by the Objective Criteria Scoring Tool, Score on admission_____

When your family member no longer meets **both** criteria, he/she will be discharged from the program. Though your family member may have substantial care needs, they may not all require a skilled person. For example, bathing, getting up, range of motion exercises, applying splints, and feeding do not require a skilled nurse. Only skilled needs are used to determine eligibility for this program.

Recipient's Rights in the EPSDT Private Duty Nursing Program

1. You have the right to discontinue services at any time by notifying your Health Care Coordinator.
2. You have the right to change nursing agencies or equipment companies if you become dissatisfied with your current provider. In some areas there are a lack of providers, if you wish to change, please contact your Health Care Coordinator and she will assist you in locating another provider.
3. You have the right to be treated with courtesy and respect by all persons with whom you come in contact that are associated with the EPSDT Private Duty Nursing Program. If you feel you are not being treated with courtesy and respect, please contact the CBC Supervisor at DMAS (804) 786-1465.
4. You have the right to appeal any decisions made by the Health Care Coordinator.

Parental/Caregiver Responsibilities

1. You have the responsibility to provide care when there is no nurse present in the home.
2. You have the responsibility to provide care or arrange care when a nursing agency is unable to staff a shift due to illness, weather or other reasons.
3. You have a responsibility to inform the nursing agency, in advance, when you do not need a nurse during an otherwise scheduled shift.
4. You have a responsibility to properly care for all equipment provided by DMAS. This includes preventing children from playing with or abusing equipment.
5 You have a responsibility to notify your DME provider when supplies or equipments are not being used or are not needed in the quantity being supplied.
6. You have a responsibility to inform your Health Care Coordinator of any change in the recipient's condition, whether an improvement or a deterioration. You must also notify the Health Care Coordinator and the nursing agency if the recipient is hospitalized.
7. You have a responsibility to notify your Health Care Coordinator if you believe you need to change the plan of care.

Nursing Agency Responsibilities

1. The nursing agency is responsible for providing skilled nurses in accordance with the plan of care developed by you and your Health Care Coordinator.
2. The nursing agency is responsible for providing nurses who are on time, clean, professional and attentive to the health needs of the recipient.
3. The nurses are responsible for caring for your family member's health needs; they are not baby-sitters, or chauffeurs. Nurses are **not** allowed to transport the recipient in a car, however, they are allowed to accompany the recipient in a vehicle if it is necessary for him/her to go out.
4. If your nursing agency is unable to staff a shift, it has a responsibility to try and make-up the missed hours within 72 hours of the missed shift. However, if the agency is unable to make up the missed hours during this time period, the hours cannot be made up at a later date.

Health Care Coordinator Responsibilities

1. The Health Care Coordinator (HCC) has a responsibility to regularly assess the recipient for continued eligibility to receive private duty nursing services. This should include, at minimum, a home visit every 6 months.
2. The HCC has a responsibility to work with you to develop a plan of care that meets the recipient's medical needs.
3. The HCC has a responsibility to help you access other services, therapies, etc. that are needed to maximize the recipient's potential.
4. The HCC has a responsibility to work with you to plan and prepare for the eventual discharge of the recipient from waiver services.

SIGNATURES

Caregiver_____ Date_____

HCC_____ Date_____

To reach your HCC you may call (804) 786-1465 or 1-888-323-0589
In Southwest Virginia please call (540) 857-7342